

St. Michael - Albertville Early Childhood Screening – Parent Consent

Child's Name _____ Birth Date ___/___/___ Parent(s) _____

Early Childhood Screening includes:

- Review of your child's immunization record
- Check of your child's height and weight
- Tests for possible hearing problems
- Tests for vision and eye health
- Check of your child's development
- Information about your child's health care and insurance
- Review of any other factors that might interfere with your child's health, growth, development or learning
- Your report on your child's growth and learning
- Information about community resources and programs based on your child's or family's needs

This screening does not replace on-going care from your health care provider or dentist.

Child and Parent Rights, Obligations and Assurances

1. The standards for screening are the same for every child regardless of race, income, creed, sex, national origin, or political beliefs.
2. Screening is required for your child's entry into the public school kindergarten or first grade. This requirement is met if your child has participated in a screening through Head Start, child and teen checkups, or equivalent screening through another provider within the past year. The screening summary results must be given to your child's school district.
3. Screening is not required if you are a conscientious objector to screening.
4. You have the right to refuse any of this screening for your child and still receive any of the other screening parts.
5. You have the right to refuse referral for assessment, diagnosis, and possible treatment for your child.
6. Your child's medical assistance eligibility or eligibility in any other health, education, or social service programs will not be affected if you refuse this screening or any parts of this screening.

I give permission for Early Childhood Screening for _____ (child's name)

___ Complete screening as described above ___ Screening described above except: _____

Parent/Guardian Signature _____ Date ___/___/___ Relationship to child: _____

Consent to Release Information

St. Michael - Albertville Schools uses information from Early Childhood Screening to identify any possible problems that might interfere with your child's health, growth, development or learning. Under Minnesota law screening results are classified as private data. The results cannot be released or discussed with anyone without your consent. If you refuse to release this information, it will not affect your child's eligibility for medical assistance or any other health, education or social service program.

Information may be used for the following purposes:

1. To obtain follow-up services for your child after the screening.
2. To arrange for further evaluation or assessment of your child's health, growth, development or learning.
3. To fulfill the requirements for your child's entrance into public school.
4. To evaluate screening programs by the Minnesota Department of Health, Minnesota Department of Education and/or the Department of Human Services. Your child's name will not be identified in any evaluation results.

I hereby authorize release of my child's screening information to the following checked programs or services for the purpose of evaluation, assessment, diagnosis, follow-up, and/or programming.

___ Child care provider

___ Dentist/Heath Care (provider name) _____

Early Childhood Family Education (ECFE) / Early Childhood Special Education (ECSE) / School Readiness

___ Mental Health agency and or Public health agency / WIC

School District

___ Other _____

Parent/Guardian Signature _____ Date ___/___/___ Relationship to child: _____